esse HEALTH
We want you well.

PEDIATRIC REGISTRATION/UPDATE FORM

– PLEASE PRINT FIRMLY –
– COMPLETE ALL SECTIONS –

CHART NO. _____

TODAY'S DATE _____

PATIENT INFORMATION

Patient's Name _____ [ ] Male [ ] Female
LAST FIRST MI

Social Security Number _____

Date of Birth _____ Age _____ Physician _____
MO DAY YEAR

HEALTH INSURANCE INFORMATION

MUST BE COMPLETED FOR ESSE HEALTH TO BILL YOUR INSURANCE COMPANY

PRIMARY INSURANCE

Name of Insurance Plan _____

Name of Person Who Carries Insurance _____

Insurance Identification Number _____

Group Number or Name of Employer _____

Date Insurance Began _____

[ ] HMO [ ] PPO [ ] OTHER

Copay _____

SECONDARY INSURANCE

Name of Insurance Plan _____

Name of Person Who Carries Insurance _____

Insurance Identification Number _____

Group Number or Name of Employer _____

Date Insurance Began _____

[ ] HMO [ ] PPO [ ] OTHER

Copay _____

PARENTS INFORMATION

Parent 1 Name _____
LAST FIRST MI

Social Security Number _____

Birthdate _____

Home Address _____

City _____ State _____ Zip _____

Phone Numbers: Home ( ) _____

Work ( ) _____ Cell ( ) _____

Email Address _____

Occupation _____

Employer's Name _____

Employer's Address _____

City _____ State _____ Zip _____

Parent 2 Name _____
LAST FIRST MI

Social Security Number _____

Birthdate _____

Home Address _____

City _____ State _____ Zip _____

Phone Numbers: Home ( ) _____

Work ( ) _____ Cell ( ) _____

Email Address _____

Occupation _____

Employer's Name _____

Employer's Address _____

City _____ State _____ Zip _____

PATIENT INFORMATION – Please List All Children We Will Be Caring For

NAME			SEX	DATE OF BIRTH	OFFICE USE	
LAST	FIRST	MI	M/F	MO/DAY/YEAR	CHART NO.	INSURANCE ID#

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I, _____, acknowledge that I am responsible and liable for all charges accessed for professional services rendered. I acknowledge that I am responsible for all charges regardless of my existing medical coverage. In the event my insurance company forwards payment directly to me, I will deliver such payment to Esse Health. I understand that I am responsible for meeting my insurance deductibles and coinsurance and any noncovered services. Should my account become past due, the balance shall become immediately due and payable. I further authorize the release to my insurance company of any medical information necessary to process a claim, and hereby assign payment of all medical benefits to Esse Health.

HOW DID YOU HEAR ABOUT US?

☐ Physician ☐ Friend/Relative
☐ Hospital ☐ Yellow Pages
☐ Insurance Co. ☐ Newspaper
☐ Other _____

Please complete so we may thank them:

Name _____

Address _____